STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000				
	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/07/11 Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Kindred Transitional Care and Rehab - Castleton was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and all resident sleeping rooms. The facility	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	has a capacity of 160 and had a census of 122 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/09/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 2 Brookshire Bistro corridor doors latched into the door frame. This deficient practice could affect any resident staff or visitor in the vicinity of the Brookshire Bistro. Findings include: Based on observation with the Part Time	K0018	K 0018 It is the practice of this facility to have doors protecting corridor openins in other than required closures, vertical openings, exits, or hazardous areas are substantial doors, capable of resisting fire for at least 20 minutes and provided with a means suitable for keeping the door closed.1. Corrective Action: No residents were affected.The latching mechanism	10/06/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Director and the Maintenance Assistant during a tour of the facility from 10:35 a.m. to 1:00 p.m. on 09/07/11, the Brookshire Bistro room has one set of double doors each equipped with a positive latching mechanism on the door. The positive latching mechanism on each door failed to latch each door into the door frame. Based on interview at the time of observation, the Part Time Maintenance Director stated the positive latching mechanism on each door failed to operate and acknowledged the the Brookshire Bistro door set did not latch each door into the door frame. 3.1-19(b)		has been adjusted and door latching properly.2. Identifying others:There is only one set of Bistro doors. Latching mechanism (door closure) a part of the preventative maintenance program and inspected monthly for proper functioning. 3. Systematic changes:The Maintenance Director/designee will educate new employees on fire safety to include proper door closure. Annual fire safety inservices will be conducted for all employees.4. Monitoring: Executive Director and/or Maintenance Director will round monthly to ensure that doors are locking properly.5. Compliance Date: 10-6-02011	
K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 12 sets of smoke barrier doors would close to form a smoke resistant barrier. LSC 19.3.7.6 requires doors in smoke barriers shall	K0027	K 0027 It is the practice of this facility to ensure that smoke barrier doors would close appropriately to form a smoke resistant barrier.1. Correction Action- No residents were affected. The set of smoke barrier	10/06/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	comply with Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect any resident, as well as staff and visitors in vicinity of the Physical Therapy room if smoke was allowed to move from one smoke compartment to another. Findings include: Based on observation with the Part Time Maintenance Director and the Maintenance Assistant during a tour of the facility from 10:35 a.m. to 1:00 p.m. on 09/07/11, the set of smoke barrier doors in the corridor near the Physical Therapy room swing in the opposite direction and failed to completely close leaving a one inch gap in between the set of doors. The door on the atrium wall side of the smoke barrier door set was hitting the top part of the door frame which caused the door to not close completely. Based on interview at the time of observation, the Part Time Maintenance Director stated the smoke barrier door set did not close completely because the door on the atrium wall side was hitting the top of the door frame and acknowledged the smoke barrier door set failed to close completely leaving a one inch gap in between the set of doors.		doors in the corridor near the Physical Therapy room were realigned such that the doors were able to close completely.2. Identifying Others- Smoke barrier doors were inspected and found to be in proper working order. These barrier doors are a part of our preventative maintenance program and will be inspected monthly for proper functioning. 3. Systematic Changes- The Maintenance Director/designee will educate new employees on fire safety to include proper door closure. Annual fire safety inservices will be conducted for all employees. 4. Monitoring- Executive Director and Maintenance Director/designee will round monthly to ensure doors are closing properly.5. The PI committee will audit findings raelated to K 0027 for 90 days.Compliance Date - 10-6-2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 11 doors serving hazardous areas such as the kitchen and the laundry each latch into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen and the laundry room. Findings include: a. Based on observation with the Part Time Maintenance Director and the Maintenance Assistant during a tour of the facility from 10:35 a.m. to 1:00 p.m. on 09/07/11, the kitchen door by the mechanical room is equipped with a self closing device and a positive latching mechanism but the kitchen door failed to	K0029	K 0029It is the practice of this facility to ensure doors serving hazardous areas such as the kitchen and laundry areas close and latch to prevent the passage of smoke. 1.Corrective Action- No residents were affected. Both kitchen and laundry room doors have been realigned and door closures adjusted to ensure proper closure.2. Identifying Others:Doors serving hazardous areas were inspected and found to be in proper working order. These closures are a party of our preventative maintenance program and will be inspected monthly for proper functioning.3. Systematic Changes- The Maintenance Director/designee will educate new employees on fire safety to include proper door closure. Annual fire safety inservices will be	10/06/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	latch into the door frame because the door would not completely close. Based on interview at the time of observation, the Part Time Maintenance Director acknowledged the kitchen door by the mechanical room would not latch into the door frame. b. Based on observation with the Part Time Maintenance Director and the Maintenance Assistant during a tour of the facility from 10:35 a.m. to 1:00 p.m. on 09/07/11, the laundry room east door set is equipped with self closing devices and positive latching mechanisms but the east door set failed to latch into the door frame. Based on interview at the time of observation, the Part Time Maintenance Director acknowledged the laundry room door set failed to latch into the door frame. 3.1-19(b)		conducted for all employees.4. Monitoring- Executive Director and Maintenance Director/designee will round monthly to ensure that door closures are in proper working order.5. Completion- 10-6-2011	
K0046 SS=F	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review and interview, the facility failed to ensure emergency lighting was provided in accordance with LSC 7.9 for 3 of 3 battery operated emergency lights for 2 of 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional	K0046	K 0046It is the practice of this facility to ensure that emergency lighting of at least 1 1/2 hour duration is provided in accordance with 7.9.19.2.9.1.1. Corrective Action- No residents were affected. The battery operated emergency light located	10/06/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	test to be conducted at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency during a loss of normal power. Findings include: Based on review of "Fire/Disaster Drill Report" documentation with the Part Time Maintenance Director from 8:55 a.m. to 10:35 a.m. on 09/07/11, documentation of functional testing at 30 day intervals for three of three battery powered emergency lights was not available for review for June and July 2011. Based on interview at the time of record review, the Part Time Maintenance Director stated the facility has three battery powered emergency lights (two at the generator location and one in the transfer switch room) and acknowledged there was no written record of a monthly function test regarding the battery powered emergency lights for June or July 2011 available for review.		at the generator worked properl upon inspection, however no documentation to show the monthly test was provided. The monthly testing is now included on the Generator Preventative Maintenance Log Sheet. The facility has undergone a change in the Maintenance Director position and the new Director will be in place by October 1, 2011.2. Identifying Others- There is only one battery operated back up light for the generator and it was in proper working order at the time of the inspection.3. Systematic Changes- Monthly testing of the battery operated back up light for the generator is now included in the monthly Generator Preventative Maintenance Log Sheet. Executive Director/ Maintenance mentor will educate new Maintenance Director on the completion of the log.4. Monitoring- Executive Director and Maintenance Director/designee will review Generator Preventative Maintenance Log monthly x 3 months and then quarterly thereafter to ensure compliance.5. Compliance Date- October 6, 2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Fire/Disaster Drill Report" documentation with the Part Time Maintenance Director from 8:55 a.m. to 10:35 a.m. on 09/07/11, there is no documentation available for review of a fire drill conducted on the third shift for the fourth quarter of 2010. Based on interview at the time of record review, the Part Time Maintenance Director acknowledged there was no	K0050	K 0050It is the practice of this facility to conduct quarterly fire drills on all three shifts and keep proper documentation of the drills. 1. Corrective Action- No residents were affected. Executive Director is monitoring quarterly fire drill documentation to ensure that they are being completed, documented correctly and readily accessible upon request. New Maintenance Director will be in place by October 1, 2011.2. Identifying Others- Quarterly fire drills are being conducted by the Maintenance Director/designee.3. Systematic Changes- Executive Director will monitor the quarterly fire drill documentation to ensure that it is being documented correctly and readily accessible upon request.4.Monitoring - Executive Director will monitor the	10/06/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation available for review of a fire drill being conducted on the third shift for the fourth quarter of 2010. 3.1-19(b)		quarterly fire drill documentation to ensure that it is being documented correctly and readily accessible upon request. 5. The PI committee 5. Completion Date- October 6, 2011.	
K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen.	K0069	K 0069It is the practice of this facility to ensure that cooking facilities are protected in accordance with 9.2.3.19.3.2.6, NFPA 96.1. Corrective Action Taken - No residents were affected. The kitchen exhaust system was cleaned on 6-25-2010, 4-16-11. Kitchen exhaust system was also cleaned on 9-9-11 by Good Exhaust Cleaning , LLC.2. Identifying Others- Does not involve any other system.3. Systematic Change - Executive Director to contract with Good Exhaust Cleaning, LLC for scheduled cleaning of kitchen exhaust system. Also, part of Preventative Maintenance program that Maintenance Director is responsible to oversee.4. Monitoring- Executive Director and Maintenance Director/designee to monitor for compliance and to ensure documentation is easily accessible. 5. The PI committee5. Compliance Date- October 6, 2011.	10/06/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on review of Good Exhaust Cleaning, LLC "Invoice" records with the Part Time Maintenance Director from 8:55 a.m. to 10:35 a.m. on 09/07/11, documentation indicated the kitchen exhaust system was last cleaned on 04/16/11 and was previously cleaned on 06/25/10 but no documentation of semiannual cleaning after 06/25/10 was available for review. Based on interview at the time of record review, the Part Time Maintenance Director stated no semiannual cleaning was performed after 06/25/10 and acknowledged no documentation of semiannual kitchen exhaust system cleaning after 06/25/10 was available for review. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 3 of 52	K0144	K 0144It is the practice of this facility to inspect generators weekly and to exercise under load for 30 minutes per month in accordance with NFPA 99.3.4.4.1.1. Corrective Action -	10/06/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Monthly Log Sheet/Weekly Engine Exercise" documentation with the Part Time Maintenance Director during record review from 8:55 a.m. to 10:35 a.m. on 09/07/11, weekly emergency generator starting battery inspection records for the fifty two week period from 09/03/10 through 08/26/11 was documented and maintained except for the first three weeks of April 2011. The only		No residents were affected. Maintenance Director position has been changed and the new Director to be in place by Oct.1, 2011. New Director has been educated by the Executive Director on the proper testing of the generator and documentation requirements. Facility has contracted with Buckeye Power to have a remote manual stop installed on the generator.2. Identifying Others- Records were maintained for the other 49 weeks of the year of the starting batteries for the emergency generator.3. Systematic Changes- Executive Director contracting with Buckeye Power for Preventative Generator Maintenance to include full load testing, as well as updating generator to regulatory code changes. 4. Monitoring- Executive Director and Maintenance Director/designee to validate the remote manual stop has been installed on the generator and contract has been implemented. 5. The PI Committee will audit compliance related to K0144 for 6 months.Compliance Date- October 6, 2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation of weekly starting battery inspections in April 2011 available for review was for the week of 04/29/11. Based on interview at the time of record review, the Part Time Maintenance Director acknowledged no documentation of weekly battery inspections for the first three week period of April 2011 was available for review. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. NFPA 110, 7-1 states NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, contains mandatory requirements for emergency generators and shall be considered part of the requirements of this standard. NFPA 37, 8-2.2(c) requires emergency generators of 100 horsepower			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of more have provisions for shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Part Time Maintenance Director and the Maintenance Assistant during a tour of the facility from 10:35 a.m. to 1:00 p.m. on 09/07/11, no evidence of a remote shut off device was found for the 100 kW diesel fired emergency generator. Nameplate information on the emergency generator did not indicate the year of manufacture. Based on interview at the time of observation, the Maintenance Assistant stated the emergency generator was installed at least eight years ago and acknowledged there is no remote emergency shut off device for the emergency generator. 3.1-19(b)			